



OIL AND WATER? LESSONS FROM MARYLAND'S EFFORT TO PROTECT SAFETY NET PROVIDERS IN MOVING TO MEDICAID MANAGED CARE

MARSHA GOLD, ScD, JESSICA MITTLER, MPP, MHSA,
AND BARBARA LYONS, PhD

ABSTRACT Studies have highlighted the tensions that can arise between Medicaid managed care organizations and safety net providers. This article seeks to identify what other states can learn from Maryland's effort to include protections for safety net providers in its Medicaid managed care program—HealthChoice. Under HealthChoice, traditional provider systems can sponsor managed care organizations, historical providers are assured of having a role, patients can self-refer and have open access to certain public health providers, and capitation rates are risk adjusted through the use of adjusted clinical groups and claims data. The article is based on a week-long site visit to Maryland in fall 1998 that was one part of a seven-state study. Maryland's experience suggests that states have much to gain in the way of "good" public policy by considering the impact of their Medicaid managed care programs on the safety net, but states should not underestimate the challenges involved in balancing the need to protect the safety net with the need to contain costs and minimize the administrative burden on providers. No amount of protection can compensate for a poorly designed or implemented program. As the health care environment continues to change, so may the need for and the types of protections change. It also may be most difficult to guarantee adequate protections to those who need it most—among relatively financially insecure providers that have a limited management infrastructure and that depend heavily on Medicaid and the state for funds to care for the uninsured.

Dr. Gold is a senior fellow and Ms. Mittler is a health research analyst at Mathematica Policy Research in Washington, DC. Dr. Lyons is a vice president at the Henry J. Kaiser Family Foundation.

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Correspondence: Marsha Gold, ScD, Senior Fellow, Mathematica Policy Research, Inc., 600 Maryland Avenue, SW, Suite 550, Washington, DC 20024. (E-mail: mgold@mathematica-mpr.com)

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Studies highlight the potential tensions between Medicaid managed care and safety net providers, some of the strategies being employed by safety net providers to deal with them, and what we know about the effects of Medicaid managed care on the safety net.¹⁻⁷ While experience differs across states and communities, providers primarily serving low-income populations often rely heavily on Medicaid revenue to supplement available direct funds for care to uninsured people. Medicaid managed care threatens this current practice because of the risk that it will redirect Medicaid patients to other providers and reduce payment levels for individual services. Such concerns are particularly acute among providers that depend heavily on Medicaid. While the role played by safety net providers varies across communities, as does the experience with Medicaid managed care, the Institute of Medicine⁸ recently concluded that there are justifiable grounds for concern about the vitality of the safety net—especially as the number of uninsured is growing at the same time that Medicaid enrollment declines.

The degree to which Medicaid managed care is structured to protect safety net providers varies significantly across states. For example, Oregon's program assumes that safety net providers need to compete on a level playing field, and their program by design did not treat safety net providers differently from others for the most part.⁹ California's two-plan model is structured uniquely to guarantee that extensive public systems, such as those in Los Angeles, maintain a specific market share, requiring that one of the two choices offered by a publicly sponsored plan involves safety net providers and has a guarantee of a specific share of enrollees.

The types of guarantees California uses to protect its safety net exceed those most states are willing to pursue. Yet, states exhibit considerable interest in strategies for employing Medicaid managed care while limiting the adverse effects on the safety net. Maryland's Medicaid managed care program—HealthChoice—is particularly instructive.¹⁰ It includes various features—currently under consideration by other states—aimed at protecting safety net providers as the state moves toward capitated managed care. Further, several of the features—such as risk adjustment and open access to some types of providers—are program components that other states have considered, but few have adopted.

Here, we review the context and method of our study of Maryland, provide a brief description of the HealthChoice program, describe Maryland's experience with four particular policies aimed at protecting the safety net, and outline the

lessons associated with recent experience in Maryland and the other states we studied.

STUDY CONTEXT AND METHODS

This paper is based on a case study of Maryland developed from interviews conducted over 1 week in fall 1998, as well as on a review of program documentation and a review of and update to the draft by interviewees at the end of 1998. During the 5-day site visit, we interviewed individuals who brought both state and local perspectives to the issue of managed care. Local interviews focused on the viewpoint of providers, participating health plans, and consumers affected by the HealthChoice initiative in three diverse communities: Baltimore City, Prince George's County (on the border of the District of Columbia), and rural western Maryland (Washington County). At the time of the study, Maryland's program had been in operation for 16 months. The case study was funded by the Henry J. Kaiser Family Foundation and is part of a larger program involving case studies of seven states. The other states, studied with additional support from the Commonwealth Fund, include California, Florida, Minnesota, Oregon, Tennessee, and Texas. We drew on the experience of these states in interpreting the Maryland experience.

OVERVIEW OF THE MARYLAND PROGRAM

Maryland's HealthChoice program replaced an earlier mandatory primary care case management system—Maryland Access to Care (MAC)—that complemented a health maintenance organization (HMO) program enrollees could join voluntarily instead of MAC. Maryland enacted HealthChoice after studies showed that, despite improvements in generating access to primary care, MAC cost Maryland more than the program it replaced and did not appear to be effective in coordinating care.¹¹ Before HealthChoice was launched, HMOs accounted for about 20% of the state's Medicaid enrollment.

HealthChoice, authorized under a federal Section 1115 waiver of traditional Medicaid rules to support the demonstration, began operations on July 1, 1997, about a year after the waiver received approval and 6 months later than originally planned. Under HealthChoice, all Medicaid beneficiaries, with a few exceptions, are required to enroll in one of the allowed managed care organizations (MCOs). The exceptions include people with dual eligibility who are covered jointly by Medicare and Medicaid, those with short-term eligibility in "spend-down" status, institutionalized individuals, and small numbers of individuals in various special-

ized and other waiver programs. In addition, individuals with 1 of 60 specialized “rare and expensive” medical conditions are permitted to opt out into a special program of fee-for-service case-managed care.

From the start, HealthChoice was implemented statewide; in fact, the program employed an enrollment broker to assist in implementation. Beneficiaries received a unified provider directory for their region that listed MCO affiliations; most beneficiaries had 21 days to choose both a health plan and a provider. After that, individuals were assigned automatically to a plan (“autoassignment”). Beneficiaries were permitted to make one switch without cause in Year 1, with an annual lock-in applying thereafter. For a variety of reasons, the initial rollout process was chaotic, with call systems overloaded, errors in provider directories, and missing addresses in beneficiary files. The result was high rates of autoassignment, which initially ran between 45% and 57% monthly—among those with good addresses in the system, thus enabling receipt of mailed material. While distinct from the formal safety net protections, Maryland’s implementation problems are important to keep in mind as they have a bearing on safety net providers’ experience with HealthChoice.

In contrast to the more limited resources committed to implementation planning, Maryland invested substantially in the design of HealthChoice. The program was developed through an extensive process that lasted over a year and engaged various stakeholders in its design. Traditional providers, advocates, and beneficiary groups participated in the negotiations both during the state’s development of the program initiatives and, later, in negotiating legislative language to add explicit provisions to minimize adverse effects on the safety net. Safety net providers and advocates for low-income populations were represented heavily, and their concerns factored into a number of key features in program design.

HealthChoice contains four main features aimed at protecting the safety net:

1. Requirements that afford provider systems serving the low-income population and other entities an opportunity to sponsor health plans without becoming licensed as an HMO if they meet fiscal solvency and quality standards.
2. A backup requirement that gives the state authority to require an MCO to include a historical provider on its panel (guaranteeing historical providers participation in at least one plan).
3. Allowance of self-referral and open access to certain providers, such as school-based clinics and family planning services, so that enrollees can

refer on their own and not also face restricted choices, and the requirement for health plans to pay for such care even if the provider is not in their network.

4. Risk adjustment involving encounter data to implement the ACG (ambulatory care group, now called adjusted clinical groups) methodology. Risk adjustment can increase or decrease payment and is especially valuable to providers who feel they treat sicker (i.e., more expensive) patients. Conceptually, risk adjustment should mean that if MCOs sponsored by traditional providers experience adverse selection (as many believe), they are paid more than they would be absent an adjustment.*

Protection for safety net providers—especially influential urban teaching and community hospitals—has long been a hallmark of the Maryland system, a fact that other states need to consider in translating the Maryland experience. Maryland maintains the nation’s only existing all-payer rate-setting system. Public programs such as Medicaid pay hospitals on the same basis as private insurers, but at a 6% discount (a portion of which is available to other payers who meet stipulated criteria). Exceptions to requirements are extremely limited. Thus, unlike other states, managed care discounting of rates is not common. Under the Maryland rate-setting system, bad debt and charity care have always been allowable costs within reason. In recent years, the system has spread the bad debt burden among all hospitals to reduce the competitive disadvantages for institutions that provide a substantial amount of charity care. Accordingly, Maryland’s system should mean that safety net providers—at least in hospital systems—are protected better financially than in many other states and thus are more competitively positioned to move Medicaid toward managed care. The same protections,

*HealthChoice also includes other unique features that we do not discuss here because they are tangential to direct safety net protection policies. They include coordinated open enrollment with a 6-month eligibility guarantee and annual lock-in that was phased in as a vehicle for encouraging a “medical home”; an extensive variety of care management requirements and use of encounter data to support performance-based monitoring and feedback; and a distinct mental health carve-out program under the control of the Mental Hygiene Administration that consolidates Medicaid and other public mental health services, but leaves the primary responsibility for primary mental health care in the hands of health plans (for further details, see Ref. 4). In addition, Maryland’s exception allowing individuals with specified conditions or diagnoses to opt out voluntarily into the fee-for-service managed system offers a protection for specialized providers, many of which are safety net-affiliated through teaching hospitals. For the most part, these are conditions for which only one or two centers of excellence exist. Most of those eligible are children (10% are adults). The program covered 60 diagnoses and 1,500 individuals with expenses of about \$10,000 per member per month at the time of our study, although an expansion was under consideration.

however, are less available to community-based providers such as independent community health centers.

EXPERIENCE WITH FEATURES AIMED AT PROTECTING SAFETY NET PROVIDERS

ALLOWING PROVIDER SYSTEMS TO SPONSOR MANAGED CARE ORGANIZATIONS

HealthChoice allows the participation of all applicant plans that meet state requirements. Applicants can be existing HMOs or other MCOs that, while not licensed currently as a state HMO, meet financial, quality, access, and data requirements and agree to accept the capitation rates. The participation policy aims to balance concerns for beneficiary protection (by requiring a standardized set of requirements regardless of plan) against concerns for the safety net and historical patterns of care, which in Maryland, especially Baltimore City, involve voluntary health systems based on hospitals and community clinics. The expectation was that 6 to 12 MCOs would participate; in fact, 9 were under contract to HealthChoice at the outset, with service areas ranging from the entire state to subsets of counties. Depending on where beneficiaries live, they have at least two MCO choices and often more. In Baltimore City and Baltimore and Anne Arundel counties, beneficiaries can choose from any of the plans.

Of the 9 MCOs that participated at the start of the program, 3 are commercially licensed plans that operated under the previous system (see Table). Among them, the 3 plans account for two-thirds of HealthChoice enrollment and thus are dominant actors in the system. The three HMOs in HealthChoice—FreeState (a Blue Cross–Blue Shield plan), Prudential, and United Health Care—account for four of the five HMOs in the previous program. All are commercial HMOs, but FreeState's at-risk contractors include safety net systems at substantial risk. One is Total HealthCare (a plan originally started by a community health center and other providers), which participated independently in the voluntary program, but decided to subcontract in HealthChoice. Another is the University of Maryland system. Many commercially licensed MCOs in Maryland neither participate in HealthChoice nor participated in the earlier system.

Of the other 6 MCOs in HealthChoice, 4 are hospital-sponsored networks specifically formed for HealthChoice. The largest, Priority Partners, was formed by Johns Hopkins Health Care and Maryland Community Health System, a corporation owned by eight community health centers in the state. Another, Maryland Physicians Care, joins a Baltimore-based hospital and a health system in western Maryland under external management. A third, Helix Family Choice, is sponsored by five affiliated hospitals and is managed by FreeState, Blue Cross–

TABLE Medicaid Managed Care Organization Enrollment by Health Plan, 1998*

	Type	Total	Percentage Share	Service Area
All plans		314,159	100	
FreeState Health Plan	C	79,952	25	Statewide
Prudential Health Care Plan	C	75,965	24	Baltimore City, Ann Arundel, Montgomery, and Prince Georges counties
United HealthCare of the MidAtlantic†	C	56,729	18	Statewide except Garrett County
Priority Partners	P	36,517	12	Statewide except Garrett County
Maryland Physicians Care	P	23,090	7	Statewide except Caroline, Dorchester, Kent, Prince Georges, Queen Anne, Somerset, Talbot, Wicomico, and Worcester counties
Helix Family Choice	P	13,734	4	Baltimore City, Ann Arundel, Baltimore, Carroll, Harford, and Howard counties
New American Health‡	P	12,406	4	Baltimore City, Ann Arundel, Baltimore, Calvert, Caroline, Carroll, Cecil, Charles, Harford, Montgomery, Prince Georges, Queen Anne, St. Mary's, and Talbot counties
Prime Health Corporation	O	12,389	4	Baltimore City, Ann Arundel, Baltimore, Calvert, Charles, Harford, Montgomery, Prince Georges, and St. Mary's counties
JAI Medical Systems	O	3,377	1	Baltimore City and Baltimore County

Source: Maryland Department of Health and Mental Hygiene enrollment report as of August 29, 1998, and MCO comparison chart (June 1, 1998).

C = commercial HMO; P = provider-sponsored system (all involve hospital systems, but Priority Partners is a partnership between the Hopkins system and a community center-sponsored organization); O = other, privately sponsored but heavily provider based.

*As of May 2000, HealthChoice had eight participating health plans. Americaid Community Care—a for-profit plan specializing nationally in care systems for the Medicaid program—replaced Prudential Health Care.

†Also known as Chesapeake Family First.

‡Withdrawing from the program.

Blue Shield's MCO that participates independently in HealthChoice. A fourth, New American, was a small plan that later withdrew from the program after its parent hospital system decided that it did not want to be involved in the managed care business. The other two plans, although based heavily on providers, are owned privately. PrimeHealth is a new HMO with strong links to minority physicians in Maryland's suburban counties near the District of Columbia. PrimeHealth has been in receivership for the past 2 years. Reportedly, a national company (Universal) with a strong Medicaid managed care business is seeking to acquire it. The other is JAI Systems, a small minority clinic with links to three well-established clinics in the Baltimore area.

Maryland's plan participation requirements provide a mechanism that permits larger provider systems that have historically played an important role in Medic-

aid to participate in HealthChoice on a basis equivalent to that of the existing MCOs. Many of the plan participation arrangements are good examples of organizational innovations on the part of provider consortia that already care for the Medicaid population and are committed to doing so for the long term. For several systems, the formation of their own plans was apparently more attractive than subcontracting with existing HMOs, although provider-sponsored MCOs experienced some operational problems in establishing systems. The problems for the most part did not seem to interfere with their ability to participate in the program and probably were what any new plan would face.

States considering plan participation options need to develop realistic expectations. Factors that appear to have contributed to Maryland's initial success include the composition of its safety net hospitals and community health centers; the historical role of the institutions in caring for Medicaid beneficiaries; the financial health and resources available in Maryland hospitals and the protections afforded by the all-payer rate-setting system; and the state's commitment to consistent regulation of all MCOs in HealthChoice, availing itself of the expertise in the insurance commissioner's office.

Despite Maryland's favorable situation, enrollment in new MCOs was limited; in addition, not all safety net providers want to form their own plans. For example, a health center-based plan that participated independently in the earlier system (Total Healthcare) and the University of Maryland system of providers both decided not to participate directly as MCOs, but rather to subcontract with FreeState on a risk basis by which they are capitated by the HMO for the enrollees they serve.

Further, many of the MCOs newly formed expressly to participate in HealthChoice and did not grow very large. They may not decide to continue as an MCO in the future. Some, like the parent of New American, which withdrew from HealthChoice, may decide that managed care is not an appropriate line of business. Others, such as PrimeHealth, may encounter financial problems and potentially be acquired by outside organizations. All participants, whether safety net-formed or not, will be influenced by the overall parameters of the expectations of the state. In Maryland, for example, both MCOs and providers have voiced tremendous concern over the extensive care management requirements. While MCOs and providers do not necessarily disagree with the intent of the requirements, they have substantial concern for the ambitious demands they place on care providers and for their effect on administrative costs in a program that sets rates seeking a 10% savings. These are the same types of factors often cited by MCOs as general reasons for not participating in Medicaid managed care. Though

safety net providers may weight requirements or payments differently from commercial MCOs (given safety the already extensive role of safety net providers in treating Medicaid patients), they are still MCOs and face many of the same business requirements faced by other MCOs.

PROTECTIONS FOR HISTORICAL PROVIDERS

Under Maryland regulations, MCOs applying for the program must submit extensive data on their network so that the state can assess network adequacy. In addition to information on contracted providers and capacity, applicants must supply information on procedures for selecting and changing providers, making appointments, following up on patients who fail to keep appointments, and arranging for out-of-area care and care for those with special needs.

To deal with concerns that some traditional providers might be excluded from networks and thus be prevented from participating in Medicaid, the Department of Health and Mental Hygiene retains the right to assign to participating HealthChoice health plans, in rotation for their network, historical providers who submit evidence that they meet the requirements established in the HealthChoice legislation and have applied to every MCO in their area, but were turned down or received no response. The original legislation as proposed had requirements linked to a provider's patient load over the past 5 years, but the law as enacted defined eligibility by type of entity: federal or state qualified health centers, programs training health professionals, Maryland Access to Care program providers (the earlier primary care case management program providers), local health departments, hospices, pharmacies, and others.

The intent of the assignment provision is to guarantee that traditional providers retain the ability to participate in at least one health plan. As of December 1998, HealthChoice received 62 applications for historical provider status, 17 of which had received approval. This is a relatively small share of eligible providers. Interviewees informed us that most historical providers already had contracts with MCOs, and that plans were interested in contracting with such providers to help them build a strong provider and enrollee base.

Maryland's experience suggests that network inclusion is a limited safeguard for protecting traditional providers. Care systems in Maryland and probably elsewhere operate such that historical providers frequently are either existing network participants or in demand by networks. The more pertinent issue is not whether there is a network contract, but rather whether MCOs direct patients to historical providers and whether safety net providers will be able to retain their patient base and revenue stream as mandatory managed care is introduced.

Evidence suggests that safety net providers were much more likely than other providers to have been affected adversely by the high autoassignment rates and other problems that caused patients to be assigned to a provider they did not choose. They also were affected more by the confusion among beneficiaries about how the system should work and where to seek care. For example, in Baltimore City, 8 of about 12 community health centers formed the Maryland Community Health System and entered into a partnership with Johns Hopkins Hospital to become an MCO. Yet, while Hopkins staff say they have maintained their patient flow, Maryland Community Health System (which also contracts with FreeState) has experienced a decline of 3,000 Medicaid visits. However, some affiliated centers (such as one in Prince Georges County) report that they have retained most of their Medicaid volume. Though safety net provider experiences differ, one factor contributing to adverse effects on centers is the financially precarious state of the centers, which is associated with center size and center dependence on Medicaid revenue.

ALLOWING SELF-REFERRAL AND OPEN ACCESS TO CERTAIN PROVIDERS

Under HealthChoice, MCOs are responsible for most medical care, although self-referral options are built in to support community-based providers and to ensure provider continuity. The only substantial service (other than long term) that MCOs are not responsible for is specialized mental health care.* Providers bill MCOs, which are required to pay providers not in the MCO network in accordance with the Medicaid fee schedule. For example, MCOs are required to develop coordination agreements with schools and to pay for school-based health services sought on a self-referral basis. Paid self-referral is also allowed for family planning, for pregnancy care when it affords continuity of obstetrical care (e.g., when the provider with whom care was initiated does not participate in the new enrollee's MCO), for an initial medical examination for children in state-supervised care, and for an annual diagnostic and evaluation visit for enrollees with HIV/AIDS.

Both the extent of HealthChoice's self-referral options and the requirement that such services be paid for through MCOs (funded in their capitation rates) are unusual compared with policies in other states, which typically leave most

*MCOs are responsible for all substance abuse services and for primary mental health care that they believe falls within the scope of practice and for developing arrangements for referral and coordination with the mental health system, but enrollees can also self-refer to this system, which is financed separately by the state mental health agency on an at-risk basis.

decisions up to the HMOs. With the exception of pregnancy care, we generally did not hear major complaints about the self-referral and payment provisions, perhaps because other concerns were more pressing. The self-referral requirements appear to pose challenges for continuity of care when care is delivered through both network providers and out-of-network providers who are consulted on a self-referral basis. While requiring payment ensures that MCOs (although not necessarily their physicians) eventually know of self-referred care, requiring MCOs to pay for care not under their control may hold them accountable for costs over which they can expect little control. Not surprisingly, pregnancy-related care most often surfaced as an area in which care management was difficult. (Compared with other services, pregnancy-related services have much higher visibility and volume.)

Maryland's experience suggests that limited open-access requirements and self-referral to selected services important to the public health infrastructure can have positive effects. For the most part, open access appeared acceptable to MCOs; carried too far (such as with pregnancy care), though, it may conflict with the goal of encouraging care management. We learned that requiring improved communication between school-based services and MCOs helped strengthen the infrastructure and care management of school-based clinics.

RISK-ADJUSTED CAPITATION RATES

Compared with other states, Maryland's system of payment places greater emphasis on risk adjustment and the equity of payments across MCOs. One distinguishing feature of HealthChoice is the use of ACGs to adjust rates for the health status of enrollees in different plans. Rates are set separately for specific groups of patients that are deferred by inpatient and outpatient diagnostic data.¹²⁻¹⁴ While ACGs have found application elsewhere for a variety of purposes, HealthChoice represents their first application to statewide Medicaid rate setting. The rate-setting system also includes mandatory stop-loss provisions (with case management) to limit risk exposure for plans once patient expenses reach a prescribed level (now \$61,000, at which point the patient remains in the MCO, but the MCO assumes responsibility for only 10% of inpatient costs and the state pays the rest).

Under Maryland's system, capitation rates are set at 90% of the estimated historical cost of fee-for-service care for benefits included under the MCO capitation payment. Separate rate cells are established for eligible individuals grouped broadly into two sets that correspond to the traditional two major types of welfare eligibility: Aid to Families with Dependent Children (AFDC) (primarily low-income families and children) and Supplemental Security Income (SSI) (primarily

aged, blind, and disabled individuals). ACG assignment is based on service-level data that include diagnoses for inpatient and outpatient care. Until the advent of HealthChoice, Maryland did not require MCOs to provide data on each unit of service ("encounter data") as is typical in fee-for-service billing. Maryland thus uses ACGs only to adjust rates for enrollees with 6 months or more claims experience; more specifically, HealthChoice relies on nine separate diagnostic categories (rule-adjusted categories, RACs), with further adjustments based on location (Baltimore City versus other locations). Rates for eligible individuals without claims experience are set on a more traditional basis that uses age/sex/geography for adjustment. Traditionally rated individuals include those already enrolled in MCOs before the launch of HealthChoice, as well as new individuals eligible for the program.

Because of its perceived equity, risk adjustment has gained widespread support in Maryland. However, the technical design of the HealthChoice risk-adjustment system remains the subject of debate. In particular, the decision to combine existing MCO enrollees with new individuals eligible for Medicaid in the same risk pool has triggered controversy. New plans (mostly provider sponsored) fear that combined risk pooling will affect them adversely because MCO enrollees under the previous system (which had as participants commercial, but not new, MCOs) included few individuals on Supplemental Security Income. In fact, some evidence suggests that fears are not without basis.¹⁵ Another concern is that the nine diagnostic groups may not provide stable risk adjustment when some plans have small enrollments. Separating HIV from AIDS in the risk-adjustment categories has also been controversial, particularly for providers that do not see many people of both types and thus are unable to cross subsidize high payments for one against low payments for others. Commercially licensed HMOs have also disagreed with mandatory stop loss since they would prefer to purchase such coverage independently.

The overarching issue associated with risk adjustment is its feasibility over time. The design of the system assumed that encounter data in usable form would be available more rapidly than appears to be the case. The built-in lag between claims experience and rate projection provides the state with a cushion to use fee-for-service claims pre-dating HealthChoice to set rates through 2000. After 2000, however, the state will need usable encounter data to continue ACG-based risk adjustment. All these problems limited the ability of risk adjustment to protect providers who serve "sickies" (patients whose care is more costly).

Assuming that operational issues can be addressed, Maryland's use of ACGs represents an important advance in work on risk adjustment that has the potential

to help safety net and other providers. Such adjustment is particularly valuable in Medicaid because different Medicaid eligibility criteria (e.g., low-income families vs. aged, blind, or disabled individuals) lead to differences in need and likely expenses for subgroups covered under the program. AGC-based risk adjustment is also important in states such as Maryland that deliberately structure their program in ways that may result in differences in risk distribution across health plans because of either their HMO experience or the types of patients their providers attract.

Maryland's experience also shows that it is difficult to communicate effectively about the complexity of risk-adjustment methods—whether the target audience is the staff that use the methods, MCOs that may live by them, or the policymakers that must interpret experience under them. Keeping such systems simple and easy to understand is valuable, particularly if simplicity can be achieved with limited loss of precision. Purchasers also need to recognize that MCOs will want to be able to replicate the computations used in setting rates and to understand how their plan is affected by annual change. In Maryland, risk adjustment became an overwhelmingly distracting issue when attempts to correct an error in calculating rates in Year 1 (which had the effect of overpaying MCOs) led to a change in the weights used for different rate cells in Year 2, along with changes in the algorithm used to assign enrollees to cells. The lack of notice of the change, the difficulty of cross-walking the change from year to year, and the magnitude of the financial impact spurred substantial legislative study, including a focus on cross-plan equity (because some MCOs had more individuals in cells adversely affected). Ultimately, Maryland decided to correct the error (to make payments consistent with the intended risk adjustment), but not to attempt to recapture from health plans and providers much of the associated cost (so that health plans would be affected less adversely and recognize the demands imposed by HealthChoice). HealthChoice fortunately had accrued sufficiently adequate savings in other areas that additional funding was not an issue it would otherwise be.

LESSONS FOR SAFETY NET PROTECTION: MARYLAND'S EXPERIENCE IN CONTEXT

Maryland's experience suggests that explicit consideration of safety net effects in developing a Medicaid managed care strategy is valuable because it forces policymakers to consider their goals up front and to decide how program policy can be structured best to balance competing interests while accounting for features unique to the care delivery environment.

Such deliberation led policymakers in Maryland to include several features aimed at supporting safety net providers in their traditional roles and making them accountable for the same type of performance standards desired system-wide. It made sense for the state to provide an option that allows health systems to form MCOs as a means of retaining their autonomy and to be included in the transition to managed care. A good risk-adjustment system is a critical corollary to fostering safety net plan sponsorship since it makes equity more likely across MCOs that may treat different patients. Similarly, Maryland's focus on open access and self-referral as a way of maintaining critical public health functions provides an incentive, otherwise likely to be lacking, for MCOs to consider the issue of spillover effects and to work with more traditional providers.

Despite these positive signs, Maryland's experience also highlights the limits that states are likely to encounter in seeking to protect the safety net. Maryland found that an explicit focus on safety net protection is not enough if the overall Medicaid managed care program has weaknesses that generate adverse operational effects. That is, it is valuable to make it possible for safety net providers to participate in the system, but this only means something if it is a system that works. At a minimum, expecting more of plans and providers than the state may be willing to pay for leads to tension, as in Maryland, which imposed substantial quality requirements while seeking a 10% savings.*

Maryland intends to use encounter data to monitor plan performance. MCOs and providers, however, expressed concern over the demands imposed by these care delivery and associated data requirements, especially at the point of patient care. Practical problems meeting the requirements include difficulties locating individuals (when address files are poorly constructed, with gaps or errors), issues related to communicating health risk information from broker to plan to participating provider, and the cumulative burden of the requirements on providers, particularly those in small offices that lack the infrastructure to handle

*Maryland regulations hold MCOs responsible for providing timely preventive and primary care. Beneficiaries are to be seen within 90 days of enrollment unless their health risk appraisal (obtained at enrollment by the broker) shows that they are at high risk, in which case they need to be seen within 15 days. Enrollees must be notified about wellness services, and there are specific standards for scheduling appointments of different types. Special protections are accorded to seven groups of individuals with special needs: homeless individuals, pregnant and postpartum women, children with special needs, individuals with developmental disabilities, individuals with physical disabilities, individuals with HIV/AIDS, and individuals in need of substance abuse treatment. These people also are entitled to have their care coordinated and managed in accordance with special standards.

the burden and that have little experience with Medicaid and its documentation requirements.

Maryland's experience also shows why a sound implementation process is just as important as design in developing a sound program. Rapid implementation of broad-based enrollment when administrative systems are not established to handle it results in confusion and high rates of autoenrollment. In particular, some individuals in Maryland (such as the homeless) had no idea they had been assigned to a plan. Implementation problems may most adversely affect providers who need protection the most because of their limited capacity to offset losses or transitional costs. Though many components of the Maryland system have merit, the state's experience shows that it was not practical to pursue them all at once. For example, the state's analytic infrastructure (e.g., encounter data) could not support the demands of risk adjustment and quality monitoring. In addition, it was difficult to put extensive care management requirements into effect quickly among providers whose practices could support them and whose plans were not structured to provide the communication technology needed to transfer information from state to plan to provider and back, particularly on a real-time basis.

A look at Maryland together with our other study states also highlights how the Maryland experience relates to the broader issues of coverage, a concern in many states. Our research across multiple states suggests that the effects of Medicaid managed care on the safety net—and the tradeoffs likely to be required between competing objectives—vary by state and community. While it is difficult to disentangle cause from effect, it would appear that it is easier to protect the safety net under Medicaid managed care, under which it already has some protections that leave it stronger and more able to compete. These protections include a strong independent funding stream for safety net providers and a well-developed management infrastructure. For example, hospitals in Maryland have benefited from a rate-setting system that includes all payers and that compensates hospitals for the reasonable costs of the uninsured. That, plus the fact that Maryland hospitals tend to have a mixed payer base, means that hospital systems are stronger financially and will be better able to position themselves when the state moves to Medicaid managed care. In Florida and in some Texas hospital districts such as Dallas (Parkland Hospital), tax-supported local financing and strong teaching affiliations that generate a diverse patient mix have enhanced the capacity of the public hospital to compete.^{16,17} But, independent funding alone is not sufficient. Some hospital districts in Texas (Houston and Fort Worth) were still

affected adversely by Medicaid managed care despite funding because they were highly dependent on Medicaid funds and had weaker management that was not as able to position the institutions to prosper under a more competitive environment.

Our studies suggest that protecting the safety net is most difficult in states and communities where safety net providers shoulder most of the burden of care for both the uninsured and Medicaid patients, resulting in a commingling of funds that makes the potential loss of Medicaid patients more acute. California is a good example. The state relies on different models of managed care for counties with and without major public systems (e.g., Los Angeles vs. Orange and Sacramento counties, respectively). In Los Angeles County and in many other counties, the two-plan model evolved to guarantee the traditional public system a specific share of the market.

It is also harder to protect smaller and non-hospital-based safety net providers. As Maryland discovered, providers such as clinics are particularly vulnerable to transitional problems. For example, clinics may lose out if autoassignment is dominant in the program because clinic patients seem to be more likely to be affected by autoassignment. That is, when patients are assigned automatically, safety net providers may get a disproportionately low share assigned to them, and their ability to control this is limited because the health plan controls decisions. The design of enrollment material may also put clinics at a disadvantage if the material is organized by physician name when clinic patients identify more with the clinic than with a particular physician.

The experience of the study states also highlights the value to a state of careful consideration of all the ways Medicaid managed care may affect the safety net. In Texas, for example, several hospital districts know they will treat the uninsured anyway because the districts are responsible for indigent care. Therefore, the hospital district plans intend to compete by guaranteeing care for enrollees even if they lose Medicaid coverage. Giving hospital districts a role in the system can encourage continuity of care when there is extensive movement of Medicaid-eligible people on and off the rolls. Texas initially did not require health plans sponsored by public hospital systems to be chosen as participating plans, but later added this requirement after adverse publicity over the exclusion of the Harris County (Houston) hospital under the competitive bidding system used to select MCOs. In retrospect, the need to address this issue after the fact rather than before delayed Texas' phased implementation of Medicaid managed care.

Our work suggests that moving to Medicaid managed care inevitably will draw funds away from indigent care and from providers that treat uninsured low-

income individuals unless states consciously consider the tradeoffs and choose to structure their policies to minimize the chance of redirecting funds. Even so, adverse effects could still arise. Protection is especially important in communities where safety net providers play a critical role in caring for the uninsured and rely on program funding streams that are closely intertwined with Medicaid.

Some of the states we studied—Oregon, Minnesota, and Tennessee—made efforts to minimize the effect of disruptions on the safety net by expanding coverage and eligibility when they moved to Medicaid managed care. Despite substantial gains, all states found that their progress toward universal coverage was limited as legislative and public support for funding such expansion grew more difficult to obtain. The lack of universal coverage and the barriers to achieving it underscore the importance of considering—as Maryland, California, Texas, and Florida did in different ways—the structure of Medicaid managed care and its effects on safety net providers, especially in states concerned with low-income individuals who are covered publicly and with those not covered at all. Maryland's experience gives us a tool for understanding better the issues involved in moving the Medicaid managed care programmable features that may be relevant to protecting safety net providers and how to form realistic goals and expectations.

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